FORM A
EDUCATION VERIFICATION FORM

Forward this form directly to your Respiratory Therapy Program for completion.

Applicant's Name: _____

Matriculation Date: month/ _____ day/ _____ year/ _____

Type of Program (select only one): ☐ Bachelor's Degree

☐ Associate's Degree

☐ Certificate

This individual will/has complete(d) the program on: month/ _____ day/ _____ year/ _____

Program Director/Registrar's Name ***(Please Print)***: _____

Program Director/Registrar's Signature: _____

School Name: _____

City & State of School: _____

Today's Date: month/ _____ day/ _____ year/ _____

School Seal

Please forward this form directly to:

Composite State Board of Medical Examiners
Respiratory Care Professionals Unit
2 Peachtree Street, N.W. – 36th Floor
Atlanta, GA 30303